Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4486AGC	A. BUILDING _____ B. WING _____	C 01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST MORNING STAR CARE HOME	**7375 MOUNTAIN ASH DRIVE LAS VEGAS, NV 89147**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 1/25/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was eight. Eight resident files were reviewed and four employee files were reviewed. The facility received a grade of A.	Y 000		
Y 050	449.194(1) Administrator's Responsibilities-Oversight NAC 449.194 The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS.	Y 050		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

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Y 050	Continued From page 1 This Regulation is not met as evidenced by: klomkloklom,kl;	Y 050		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.